

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06630

6702

CERTIFICATE OF DEATH

Reg. Dist. No. 336

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 153 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Delmar</u>		LENGTH OF STAY (in this place) <u>38 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Delmar</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>110 East Street</u>				STREET ADDRESS (If rural give location) <u>110 East Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Chester Washington Baker</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 16, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATED <u>Married</u>	8. DATE OF BIRTH <u>June 27, 1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Gumboro, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter William Baker</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Evans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-05-9264</u>		17. INFORMANT & ADDRESS <u>Iona Baker, Delmar, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>4201 coronary thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>coronary arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 15, 1956</u> to <u>June 16, 1956</u> that I last saw the deceased alive on <u>June 15, 1956</u> and that death occurred at <u>5:45</u> M. from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> M.D. <u>Delmar, Md.</u> DATE SIGNED <u>6-16-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-18-56</u>		NAME OF CEMETERY OR CREMATORY <u>Byrd</u>		LOCATION (City, town, or county) (State) <u>Mears, Va.</u>	
24. REC'D BY REGISTRAR DATE <u>6-19-56</u>		REGISTRAR'S SIGNATURE <u>Harry C. Anderson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Marvel Co. Delmar Del</u>		ADDRESS	

1000

BUREAU V. S.

JUN 19 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

86631

6793

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH CITY/TOWN: <u>WICOMICO</u> MARYLAND COUNTY: <u>WICOMICO</u> CITY (If outside corporate limits, write RURAL and give nearest town): <u>MARDELA SPRINGS</u> TOWN: <u>MARDELA SPRINGS</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS: <u>MAPLE SHADE CONVALESCENT HOME</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE: <u>MARYLAND</u> COUNTY: <u>WICOMICO</u> CITY (If outside corporate limits, write RURAL and give nearest town): <u>MARDELA SPRINGS</u> TOWN: <u>MARDELA SPRINGS</u> STREET ADDRESS (If rural give location): <u>BRIDGE ST</u>			
3. NAME OF DECEASED (Type or Print) <u>WILLIAM WASHINGTON BENNETT</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>JUNE 4 1956</u> (Month) (Day) (Year)			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>JULY 21 1874</u>	
9. AGE last birthday <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>DORCHESTER CO. VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM H. BENNETT</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA BRADLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>MAPLE SHADE CONVALESCENT HOME</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>490X IMMEDIATE CAUSE (A) PO LOBAR PNEUMONIA</u>						<u>5 DAYS</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>CEREBRAL HEMORRHAGE</u>						<u>7 WEEKS</u>	
(C) <u>CHRONIC MYOCARDITIS</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>NONE</u>				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>NONE</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>NONE</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JUNE 2, 1956</u> to <u>JUNE 4, 1956</u> , that I last saw the deceased alive on <u>JUNE 3, 1956</u> , and that death occurred at <u>9:35 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>W. E. Aptz</u>				ADDRESS (Street, city, town, state) <u>MARDELA SPRINGS</u> DATE SIGNED <u>6/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JUNE 16, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>MARDELA CEMETERY</u>		LOCATION (City, town, or county) (State) <u>MARDELA MARYLAND</u>	
24. REC'D BY REGISTRAR <u>Mary H. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Co. Salisbury Md.</u>			
DATE <u>JUN 6 1956</u>							

BUREAU V. S.

1956 6 JUN

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6646

CERTIFICATE OF DEATH

07676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN Ib <u>9 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deal Island</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>Anna</u> Last <u>Benton</u>				4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/1/1885</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Deal Island, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>GEORGE B. HORNER</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET HITCHENS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 26, 1955</u> , to <u>June 25, 1956</u> , that I last saw the deceased alive on <u>June 25, 1956</u> , and that death occurred at <u>9:10 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>6/25/56</u> ACTUAL SIGNATURE <u>L. V. Maldve</u> M.D. <u>Salisbury, Maryland</u> PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-27-56</u>		<u>ST. JOHNS CEMETERY</u>		<u>Deal Island Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Webster</u>				ADDRESS <u>Deal Island Md</u>		24a. REC'D BY REGISTRAR DATE <u>6/26/56</u>	
						24b. REGISTRAR'S SIGNATURE <u>John J. [illegible]</u> <u>May 21. [illegible]</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		35		W		1928		MEMPHIS, TENN.		4/4/68		MEMPHIS, TENN.		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS MARRIAGES		18. PREVIOUS DEATHS		19. PREVIOUS DISEASES		20. PREVIOUS INJURIES		21. PREVIOUS DRUGS		22. PREVIOUS ALCOHOL		23. PREVIOUS TOBACCO		24. PREVIOUS OTHER	
ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED		1		0		0		0		0		0		0		0	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF DECEASED		27. SIGNATURE OF REGISTRAR		28. SIGNATURE OF DECEASED		29. SIGNATURE OF REGISTRAR		30. SIGNATURE OF DECEASED		31. SIGNATURE OF REGISTRAR		32. SIGNATURE OF DECEASED		33. SIGNATURE OF REGISTRAR		34. SIGNATURE OF DECEASED		35. SIGNATURE OF REGISTRAR		36. SIGNATURE OF DECEASED	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

JUL 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6647

CERTIFICATE OF DEATH

Reg. Dist. No.

66632
332

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>R. 1</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>BOUNDS</u> Last <u>BOUNDS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 13, 1876</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired produce broker</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel D. Bounds</u>		14. MOTHER'S MAIDEN NAME <u>Sally Noble</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Beulah Bounds Princess Anne, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>6-17</u> 19 <u>56</u> , and that death occurred at <u>1:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis, M.D.</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>6-17-56</u>	
PHYSICIAN'S NAME (Type) _____		_____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6-19-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Vernon, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u>		ADDRESS <u>Princess Anne, Md.</u>	
24a. REC'D BY REGISTRAR <u>Mary W. Holloman</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES J. HENRY		AGE 45		SEX MALE		RACE WHITE		DATE OF DEATH JULY 17, 1956		PLACE OF DEATH HOME	
RESIDENCE 1000 W. 10th St., Boston, Mass.		DATE OF BIRTH AUG. 12, 1910		PLACE OF BIRTH MASSACHUSETTS		OCCUPATION RETIRED PRODUCE OPERATOR		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
U.S. CITIZENSHIP U.S.A.		MARRIAGE MARRIED		EDUCATION HIGH SCHOOL		RELIGION CATHOLIC		PREVIOUS ILLNESS NONE		HISTORY OF DRUGS NONE	
SIGNATURE OF DECEASED JAMES J. HENRY		SIGNATURE OF WITNESS JAMES J. HENRY		SIGNATURE OF PHYSICIAN JAMES J. HENRY		SIGNATURE OF CLERK JAMES J. HENRY		SIGNATURE OF REGISTRAR JAMES J. HENRY		SIGNATURE OF JURY JAMES J. HENRY	
DATE OF DEATH JULY 17, 1956		TIME OF DEATH 10:00 AM		PLACE OF DEATH HOME		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PREVIOUS ILLNESS NONE	
U.S. CITIZENSHIP U.S.A.		MARRIAGE MARRIED		EDUCATION HIGH SCHOOL		RELIGION CATHOLIC		PREVIOUS ILLNESS NONE		HISTORY OF DRUGS NONE	

BUREAU V. S.

JUN 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6648
CERTIFICATE OF DEATH

66633

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>THOMAS</u> Last <u>BRITTINGHAM</u>		4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11, 1877</u>
9a. AGE (In years last birthday) <u>79</u> yrs.		9b. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lineman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>B en Brittingham</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Ella M. Lavinia Dishroom</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no.</u>	
17. INFORMANT <u>Mrs. Ella M. Brittingham, Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic gangrene left leg</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>yes</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-16-56</u> , to <u>6-24-56</u> , that I last saw the deceased alive on <u>6-24-56</u> , 19 <u>56</u> , and that death occurred at <u>Medical Center</u> , M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry A. Brule</u> M.D.		ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>6-25-56</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Henry Brule, Medical Center Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		22b. DATE THEREOF <u>6/27/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u>		ADDRESS <u>Newman T. Baker</u>	
24a. REC'D BY REGISTRAR DATE <u>6-26-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

100

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6649
CERTIFICATE OF DEATH

66634

Reg. Dist. No. 382

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS R.D. # 1 (Union Rd.)	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MORRIS Middle WILLIAM Last BROWN		4. DATE OF DEATH Month JUNE Day 14 Year th 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1908
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Days 25 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) R.D. # 1 Salisbury, Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Thomas Brown		14. MOTHER'S MAIDEN NAME Hannah T. Farlow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Bessie J. Brown (Wife) Address R.D. # 1 (Union Rd) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Colon 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mr , 19 55 to June 14, 1956 , that I last saw the deceased alive on June 14, 1956 , and that death occurred at 8:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip A. Insley M.D. 116 E. Main St (Office) DATE SIGNED June 15 1956			
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley M.D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 17, 1956	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME—SALISBURY, MD. ADDRESS 		24a. REC'D BY REGISTRAR DATE 6-18-56 24b. REGISTRAR'S SIGNATURE May W. Holloway	

CERTIFICATE OF DEATH

FIRST NAME LAST NAME SEX AGE DATE OF BIRTH PLACE OF BIRTH		MARRIED SINGLE DIVORCED WIDOWED	
OCCUPATION PLACE OF DEATH DATE OF DEATH TIME OF DEATH		CAUSE OF DEATH MANNER OF DEATH PLACE OF INTERMENT DATE OF INTERMENT	
SIGNATURE OF DECEASED SIGNATURE OF WITNESS SIGNATURE OF PHYSICIAN SIGNATURE OF MINISTER OF THE GOSPEL		SIGNATURE OF REGISTRAR SIGNATURE OF CLERK SIGNATURE OF CHIEF OF BUREAU	

BUREAU V. S.

JUN 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6650 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6650 CERTIFICATE OF DEATH

06635

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Wor.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bishop</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Peninsula Hospital</i>		d. STREET ADDRESS <i>23X-2</i>	
3. NAME OF DECEASED (Type or print) <i>Stanley</i> First Middle Last <i>Bunting</i>		4. DATE OF DEATH Month <i>6</i> Day <i>26</i> Year <i>1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 25 1956</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Madison Bunting</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Selby</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Madison Bunting Bishop Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Decompensation</i> <i>754.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congen. Heart Disease</i> DUE TO (c) <i>Transposition of Great Vessels.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <i>June 26</i> , 19 <i>56</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Morris A. Lambdin</i> M.D.		707 Camden Ave	
PHYSICIAN'S NAME (Type) <i>Dr. Lambdin</i>		<i>Salisbury Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>6/27/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>190 F</i>		22d. LOCATION (City, town, or county) (State) <i>Bishopville Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lester Maly</i>		ADDRESS <i>Salisbury</i>	
24a. REC'D BY REGISTRAR DATE <i>6-30-56</i>		24b. REGISTRAR'S SIGNATURE <i>Mary W. Holloman</i>	

2-82293XV2

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES EARL RAY		M		35		12/1/28		MOBILE, ALABAMA		LABORER		SINGLE		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF WITNESSES		16. SIGNATURE OF REGISTRAR	
7/1/68		10:00 AM		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL		J. EARL RAY		J. EARL RAY		J. EARL RAY	
17. COUNTY		18. CITY		19. STATE		20. ZIP CODE		21. FILING DATE		22. FILING TIME		23. FILING PLACE		24. FILING OFFICE	
BALTIMORE		BALTIMORE		MARYLAND		21201		7/1/68		10:00 AM		BALTIMORE		BALTIMORE	

BUREAU V. 2

JUL 3 1966

RECEIVED

1 6651 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

Reg. Dist. No.

06636
3322

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>			
d. NAME OF HOSPITAL (If in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CANNON</u>			4. DATE OF DEATH Month Day Year <u>June 19- 1956</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19-1956</u>	9. AGE (In years lost birthday) yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u>2</u> Min. <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Marybelle CANNON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Marybelle Cannon-Fruitland Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 19, 1956</u> , to <u>June 19, 1956</u> that I last saw the deceased alive on <u>19 June 1956</u> , and that death occurred at <u>3:52 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morris C. Lambdin</u>				ADDRESS (Street, city or town, state) <u>M.D. 707 Camden, Salisbury Md.</u>			
PHYSICIAN'S NAME (Type) <u>—</u>				DATE SIGNED <u>6-20-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital, Salisbury Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital, Salisbury, Md.</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Margaret Holloway</u>	

JUN 22 1956

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06637

6652

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millsboro</u> 46X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Main ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>Amy</u> Middle <u>Ellen</u> Last <u>Clouser</u>				4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 8, 1986</u> 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel Kenney</u>				14. MOTHER'S MAIDEN NAME <u>Martha Calloway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Clarence Clouser Millsboro, Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>585X</u> DUE TO <u>Acute Pancreatitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chr. Cholelithiasis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5-6 days</u> <u>8-9 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/20/56</u> , 195 <u>6</u> , to <u>6/27/56</u> , 195 <u>6</u> that I last saw the deceased alive on <u>6/27/56</u> , 195 <u>6</u> , and that death occurred at <u>10:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William B. Long</u> M.D.				ADDRESS (Street, city or town, state) <u>Med Center Salisbury Md</u> DATE SIGNED <u>6/29/56</u>			
PHYSICIAN'S NAME (Type) <u>William B. Long</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Delmar, Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald James</u>				ADDRESS <u>Millsboro, Del.</u>		24a. REC'D BY REGISTRAR DATE <u>7-2-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Calloway</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED Samuel L. Jones		SEX Male	
DATE OF BIRTH July 1, 1900		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Clerk		CAUSE OF DEATH Heart Disease	
DATE OF DEATH July 10, 1956		PLACE OF DEATH Baltimore, Md.	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF FUNERAL HOME Jones & Sons	
NAME OF NEXT OF KIN Mrs. J. H. Smith		NAME OF BURIAL PLACE St. John's Cemetery	
NAME OF COUNTY Baltimore		NAME OF CITY Baltimore	
NAME OF STATE Maryland		NAME OF COUNTRY United States	

RECEIVED
 JUL 5 1956
 BUREAU V. 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6653 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06638

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1/2</u> hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selbyville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R F D # 2</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Mae</u> Last <u>Custis</u>				4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>19 56</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 29, 1954</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>23</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Whaleysville, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Warner Custis</u>				14. MOTHER'S MAIDEN NAME <u>Martha Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Martha Custis, Selbyville, Del.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (a) _____ (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>830.X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Child playing under car that backed over it.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>2P</u> o. m. <u>6 23</u> p. m. <u>19 56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Yard of home.</u>		20f. (City or town) (County) (State) <u>Selbyville</u> <u>Worcester</u> <u>Del.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-26-56</u>		22b. DATE THEREOF <u>6-26-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mission Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bishopville</u> <u>Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>				ADDRESS <u>Beomoke, Ind.</u>		24a. REC'D BY REGISTRAR <u>6-26-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		PREVIOUS ILLNESS	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
FAMILY HISTORY		SOCIAL HISTORY		HISTORICAL DATA		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		POST-MORTEM EXAMINATION	
FINDINGS		DISCUSSION		CONCLUSIONS		REMARKS		SIGNATURE OF EXAMINER		DATE	

BUREAU V. 8

JUN 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6654

CERTIFICATE OF DEATH

Reg. Dist. No.

18654
06639

352

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>R# 3 Box 301</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DUFFY</u>				4. DATE OF DEATH Month Day Year <u>JUNE 23 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 22, 1956</u>	9. AGE (In years lost birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>3 15</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>LOUIS SANDERS DUFFY</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Elsie DENNIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/22/56</u> , 19 <u>56</u> , to <u>6/23/56</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>6/22/56</u> , 19 <u>56</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morris C. Lambdin</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>6/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital, Salisbury, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 6-23-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED LOUIS SANDERS		AGE 44 yrs		SEX Male		RACE White		DATE OF BIRTH June 23, 1912		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Married		SPOUSE'S NAME Mary Sanders		SPOUSE'S AGE 42 yrs		SPOUSE'S SEX Female		SPOUSE'S RACE White		SPOUSE'S DATE OF BIRTH June 23, 1912	
OCCUPATION None		EDUCATION None		RELIGION None		MANNER OF DEATH Natural		CAUSE OF DEATH None		PLACE OF DEATH None	
DATE OF DEATH None		TIME OF DEATH None		PLACE OF DEATH None		CAUSE OF DEATH None		MANNER OF DEATH None		RELIGION None	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None		SIGNATURE OF PHYSICIAN None		SIGNATURE OF CLERK None		SIGNATURE OF JUDGE None		SIGNATURE OF NOTARY None	

BUREAU V. E.

JUN 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6794 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06640

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sharptown drawbridge</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finchville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>Clifford</u> Last <u>Fieldner</u>				4. DATE OF DEATH Month <u>6-16</u> Day <u>19</u> Year <u>56</u>																			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 3, 1954</u>		9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (State or foreign country) <u>Easton, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>Clifford Fieldner</u>						14. MOTHER'S MAIDEN NAME <u>Goldie Mae Quails</u>																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Clifford Fieldner, Federalsburg, Md., R.F.D.</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>824X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in car that ran through barricade off open drawbridge.</u>																			
20c. TIME OF INJURY Month, Day, Year Hour <u>9 P</u> a. m. <u>6-16</u> p. m. <u>19 56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Drawbridge</u>				20f. (City or town) <u>Sharptown</u>		(County) <u>Wicomico</u>		(State) <u>Md.</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																							
ACTUAL SIGNATURE <u>Earl L. Royer</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>6-18-56</u>											
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										22b. DATE THEREOF <u>June 19, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Federalsburg Col. Cemetery</u>				22d. LOCATION (City, town, or county) <u>Federalsburg, Maryland</u>		(State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>						ADDRESS <u> </u>				24a. REC'D BY REGISTRAR <u>6-20-56</u>				24b. REGISTRAR'S SIGNATURE <u>Mary W. Helton</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

JUN 21 1955

RECEIVED

John A. Paul

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06641

6655

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>R.D. # 2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WALTER Johnathan Figgs</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 9, 1896</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Box Maker (Employee)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>H. & H. Poultry Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Melson Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>Joseph Figgs</u>				14. MOTHER'S MAIDEN NAME <u>Rosa Parsons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Dorothy Figgs (Wife)</u> Address <u>R.D. # 2 Bishop, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic coronary thrombosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>6-16</u> , 19 <u>56</u> , and that death occurred at <u>9:10</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. R. Ellis, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>6-16-56</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Wilber R. Ellis M.D.</u>				Medical Center - Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 20, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME- SALISBURY, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>6-19-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary N. Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
JAMES H. HARRIS		Male		45		August 2, 1895		New York, N.Y.		New York, N.Y.		Heart Disease		August 10, 1955		10:00 AM		Home		J. H. HARRIS		J. H. HARRIS	
Occupation		Marital Status		Color		Height		Weight		Education		Previous Illnesses		Alcohol Consumption		Tobacco Use		Hypertension		Diabetes		Other	
None		Married		White		5' 8"		175		High School		None		None		None		None		None		None	
Signature of Informant		Relationship to Deceased		Signature of Informant		Relationship to Deceased		Signature of Informant		Relationship to Deceased		Signature of Informant		Relationship to Deceased		Signature of Informant		Relationship to Deceased		Signature of Informant		Relationship to Deceased	
J. H. HARRIS		Wife		J. H. HARRIS		Wife		J. H. HARRIS		Wife		J. H. HARRIS		Wife		J. H. HARRIS		Wife		J. H. HARRIS		Wife	

BUREAU V. S.

JUN 19 1955

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6 Film 99 6-29-56 et

66642

6656

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pen. Gen. Hospital</u>		d. STREET ADDRESS <u>807 S. Division St</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>MARIE</u> Last <u>FINK</u>		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1893</u>
9. AGE (In years last birthday) yrs. <u>62</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Work at home</u>	11. BIRTHPLACE (State or foreign country) <u>Orange New Jersey</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>John Flanagan</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah Marie McDevitt</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Alexander S. Fink (Husband)</u> Address <u>807 S. Division St Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal hemorrhage</u> <u>293X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anemia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/12</u> , 19 <u>56</u> , to <u>6/24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/24</u> , 19 <u>56</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>211 Maryland Ave. (Office) June 25, 1956</u> ACTUAL SIGNATURE <u>Dr. Andrew C. Mitchell M.D.</u> PHYSICIAN'S NAME (Type) <u>Dr. O. J. Burton M.D.</u> <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 28, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME—SALISBURY, MD</u>		24a. REC'D BY REGISTRAR <u>June 26 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6657

CERTIFICATE OF DEATH

06643

Reg. Dist. No.

932

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital				d. STREET ADDRESS Main			
3. NAME OF DECEASED (Type or print) First Mary Middle Margaret Last Fletcher				4. DATE OF DEATH Month June Day 23 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1910	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Sharptown, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl H. Bennett				14. MOTHER'S MAIDEN NAME Clara Bradley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-26-3511		17. INFORMANT Address Elva Fletcher, Sharptown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix Stage IV Inadequate DUE TO (b) Thrombosis of left femoral artery DUE TO (c) Metastatic Carcinoma to bladder CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 171X							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/17 , 19 55 , to 6/23 , 19 56 , that I last saw the deceased alive on 6/23 , 19 56 , and that death occurred at 8:00 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE William S. Womack		M.D. 706 Camden Ave.		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) William S. Womack		Salisbury Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-26-56		22c. NAME OF CEMETERY OR CREMATORY Fireman		22d. LOCATION (City, town, or county) (State) Sharptown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Mansel - Sharptown, Md				24a. REC'D BY REGISTRAR DATE 28 1956		24b. REGISTRAR'S SIGNATURE Mary H. Falloway	

JUN 28 1956

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G199 6-22-56 et

6658

CERTIFICATE OF DEATH

06644

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>4 Wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur</u> First		Middle		Last <u>GARRISON</u>		4. DATE OF DEATH <u>JUNE 15</u> 19 <u>56</u> . Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 10, 1860</u>		9. AGE (In years last birthday) <u>96</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Quantico, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Spencer Garrison</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Mrs. Maude Garrison, Tyaskin, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>5-19</u> _____, 19 <u>56</u> , to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <u>3:45 P</u> _____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>W. B. Ellis, Jr.</u> M.D. <u>Salisbury, Md. 6-16-56</u> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Town Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Tyaskin, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. P. Messick</u> ADDRESS <u>Bivalve, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>6-19-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary D. Hollaway</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06645

6659

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City, Maryland</u> <u>23-42-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>301 Clarke Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Agnes</u> Last <u>GIBSON</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23, 1878</u>
9. AGE (In years last birthday) yrs. <u>77</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Hardesty</u>		14. MOTHER'S MAIDEN NAME <u>Martha A. Poor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of femoral neck</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 17</u> , 19 <u>51</u> , to <u>June 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>56</u> , and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert J. Gore</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>6/20/56</u>	
PHYSICIAN'S NAME (Type) <u>Robert J. Gore, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 24/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Salmon M. E. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry L. Watson</u> ADDRESS <u>Pocomoke Md.</u>		24a. REC'D BY REGISTRAR <u>June 25 1956</u> DATE <u>June 25 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mary H. Hollman</u>	

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. S.

JUN 25 1956

RECEIVED

6660

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>WICOMICO</u>	MARYLAND	STATE <u>VIRGINIA</u> COUNTY <u>ACCOMACK</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
12 TOWN <u>SALISBURY</u>		<u>OAK HALL</u> 83X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Home	STREET ADDRESS (If rural give location)	
90 <u>Riverside Convalescent</u>			
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>L. FRANK</u>	(Middle) <u>GLADDING</u>	(Last)	
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Sept. 21, 1872</u>	
9. AGE last birthday: <u>83 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>23</u> Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Lumberman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>FLEMING BROS.</u>	
11. BIRTHPLACE (State or foreign country): <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Geo. W. GLADDING</u>		14. MOTHER'S MAIDEN NAME: <u>VALLY Stockely</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <u>James Gladding Oak Hall, Va</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 weeks</u>	
ANTECEDENT CAUSE (S) (B) <u>Hypertension. Arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/15/55</u> , to <u>6/14/56</u> , that I last saw the deceased alive on <u>6/14/56</u> , and that death occurred at <u>1204</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Ed M. Beardsley</u>		M. D. <u>Salisbury Md.</u> DATE SIGNED <u>6/14/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>DOWNINGS</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-18-56</u>		24. FUNERAL DIRECTOR <u>Mrs. N. A. Shields</u> ADDRESS <u>New Church, Va</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 20 1956

RECEIVED

6661

CERTIFICATE OF DEATH

06647

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		d. STREET ADDRESS 501 Anne St.	
3. NAME OF DECEASED (Type or print) First EDNA Middle WHITE Last GOSWELLEN		4. DATE OF DEATH Month JUNE Day 24 Year th 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1894
9. AGE (In years last birthday) yrs. 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (Operator) Shirt Factory	
11. BIRTHPLACE (State or foreign country) R.D. #1 Salisbury (Wor. Co.) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lawrence Bates McGrath		14. MOTHER'S MAIDEN NAME Laura Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. W. Ardie Goswollen (Husband)		Address 501 Anne St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-Intestinal and Cerebral Hemorrhage 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myeloblastic Leukemia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diverticulitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 14, 1956 , to June 24, 1956 , that I last saw the deceased alive on June 24, 1956 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas C. Hill		ADDRESS (Street, city or town, state) DATE SIGNED 224 N. Division St. (Office) June 25 1956	
PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 27, 1956	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME—SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE JUN 26 1956	24b. REGISTRAR'S SIGNATURE Mary H. Holloway

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6662

CERTIFICATE OF DEATH

Reg. Dist. No.

66648
332

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>VIRGINIA</u> b. COUNTY <u>Accomac</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>83x-3 Temperanceville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL Hospital</u>				d. STREET ADDRESS <u>83x-3</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Melvin Eldridge Gravelly</u>				4. DATE OF DEATH Month Day Year <u>June 3 1956</u>			
5. SEX <u>1 MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 30 1900</u> 55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Axton Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John L. Gravelly</u>				14. MOTHER'S MAIDEN NAME <u>Theo Eggleston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Evelyn Waples Gravelly, Temperanceville Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Myocardial infarct, acute</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-29</u> , 19 <u>56</u> , to <u>6-3</u> , 19 <u>56</u> that I last saw the deceased alive on <u>6-3</u> , 19 <u>56</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Ellis, Jr.</u> M.D. <u>Salisbury, Md.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>6-3-56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John W. Taylor Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Temperanceville Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry M. Johnson</u> ADDRESS <u>Parkside Rd.</u>				24a. REC'D BY REGISTRAR DATE <u>6-7-56</u>		24b. REGISTRAR'S SIGNATURE <u>Maryll Holloway</u>	

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
5M 9/55

1
6653 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06649

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital		e. STREET ADDRESS 506 Truitt St	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FULTON Middle EVERETT Last GRIFFIN		4. DATE OF DEATH Month JUNE Day 13 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1908
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 0 Days 5	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Employee T.L.Ruark & Co.	
11. BIRTHPLACE (State or foreign country) Berlin, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Sewell E. Griffin		14. MOTHER'S MAIDEN NAME Anna Mae Holloway	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.# 11	
17. INFORMANT Mrs. Flora H. Griffin (Wife)		Address 506 Truitt St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous subarachnoid hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 15 1956	
EXAMINER'S NAME (Type) Dr. Earl L. Royer M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 16, 1956	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME-SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE 6-18-56	24b. REGISTRAR'S SIGNATURE Mary W. Holloway

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>507 Camden Ave.</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>507 Camden Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Kirk</u> Last <u>Gunby</u>				4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>1956</u>													
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 6, 1893</u>		9. AGE (In years last birthday) <u>63</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Louis W. Gunby</u>				14. MOTHER'S MAIDEN NAME <u>Frances Graham</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WW I & II</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Joseph Y. Gunby</u> Address <u>Same</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>Earl L. Royer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6-25-56</u>													
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>6/25/1956</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Pa rsons Cemetery</u> 22d. LOCATION (City, town, or county) <u>Salisbury, Maryland</u> (State)													
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burge C. Hill</u> ADDRESS						24a. REC'D BY REGISTRAR <u>6-26-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary M. Hallonay</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WESTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John J. Doe		Male		45		White		June 2, 1956		Home	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Social History	
Heart Disease		Natural		Teacher		High School		Married		Nonsmoker	
Immediate Cause		Contributing Cause		Pre-existing Conditions		Post-mortem Examination		Autopsy		Disposition of Body	
Myocardial Infarction		Hypertension		None		None		None		Buried	
Anatomical Site		Anatomical Site		Anatomical Site		Anatomical Site		Anatomical Site		Anatomical Site	
Coronary Artery		Aorta		Lungs		Liver		Spleen		Stomach	
Thrombosis		Atherosclerosis		Emphysema		Hepatitis		Splenomegaly		Gastritis	
Coronary Artery		Aorta		Lungs		Liver		Spleen		Stomach	
Thrombosis		Atherosclerosis		Emphysema		Hepatitis		Splenomegaly		Gastritis	

RECEIVED
 JUN 27 1956
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6665

CERTIFICATE OF DEATH

06651

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>VIRGINIA</u> b. COUNTY <u>Accomac</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Withams.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>83X-3</u>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>HALL</u> Last <u>HALL</u>				4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 3, 1880</u>	9. AGE (In years last birthday) yrs. <u>75</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE OWN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>SANFORD VIRGINIA</u>	
13. FATHER'S NAME <u>RAYMOND LEWIS</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN PARKS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>DARIES T. HALL (WITHAMS, Va.)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, generalized.</u> 200.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Retention Cell Scarcum, intestines</u> DUE TO <u>c gangrene.</u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week.</u> <u>4-6 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>5-22</u> , 19 <u>56</u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William B Long</u> M.D.			ADDRESS (Street, city or town, state) <u>Med. Center, Salisbury, Md.</u> 6/16/56 DATE SIGNED				
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 17, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DOWNING CEM</u>		22d. LOCATION (City, town, or county) (State) <u>OAK HALL, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson, Pocomoke Md.</u>				24a. REC'D BY REGISTRAR DATE <u>6-19-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollaway</u>	

1955 OCT NOV

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06652

6666

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 HOURS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>FEDERAL STREET</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HANCOCK</u>				4. DATE OF DEATH Month Day Year <u>JUNE 2 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 2, 1956</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>1 30</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Arthur Hancock</u>			
14. MOTHER'S MAIDEN NAME <u>Flora Amelia Adkins</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Arthur Hancock, Snow Hill, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to <u>6/2</u> , 19 <u>56</u> , that I lost the deceased alive on <u>6/2/56</u> , 19____, and that death occurred at <u>3:07 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>William C. Morgan</u> M.D. <u>Salisbury, Md.</u> <u>6/2/56</u> PHYSICIAN'S NAME (Type) <u>William C. Morgan, M.D., Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>June 3-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Worcester, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital, Salisbury, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>6-4-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

2082293 XVI

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The text is mirrored and difficult to read.

BUREAU V. 2

JUN 5 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6667 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67696

Item 7, Film G200, 1721/56 bn

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 23-42-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Edgar Adkins Farm	
3. NAME OF DECEASED (Type or print) First George Middle McGee Last Hansley		4. DATE OF DEATH Month 6 Day 30 Year 56	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> unk DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 92 C.
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 6 Days 30 Hours 56 Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Pen. Gen Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage due to stab wound of popliteal artery 913.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) ? (a), stating the underlying cause last. DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on butcher knife during a fight.	
20c. TIME OF INJURY Month, Day, Year 10 p. a. m. 6-30-56 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Pocomoke Worcester Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 6-9-56	
22c. NAME OF CEMETERY OR CREMATORY Burgaw Cem		22d. LOCATION (City, town, or county) (State) Burgaw Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. B. D. New		ADDRESS	
24a. REC'D BY REGISTRAR 7-1-56		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66653

6668

CERTIFICATE OF DEATH

Reg. Dist. No. 222

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN lb <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. STREET ADDRESS <u>4321 Parkton Street</u>			
3. NAME OF DECEASED (Type or print) <u>J. Roy</u> First Middle Last				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/25/1887</u>	
9. AGE (In years lost birthday) yrs. <u>68</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u> Hours <u>56</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>never employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>A. P. Hardesty</u>				14. MOTHER'S MAIDEN NAME <u>Cornelia King</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca. metastases of abdomen</u> <u>157x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ca. of pancreas</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1-2 months</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Baltimore</u>				(County) (State)			
21. I certify that I attended the deceased from <u>May 29</u> , 19 <u>56</u> , to <u>June 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>56</u> , and that death occurred at <u>12:50P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Juerman</u>				ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>				DATE SIGNED <u>6/11/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>6/14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Baltimore</u>				(State) <u>Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cooke, Inc.</u>				ADDRESS <u>1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>6-13-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>							

CERTIFICATE OF DEATH

<p>STATE OF MARYLAND COUNTY OF BALTIMORE</p>		<p>DATE OF DEATH JUN 13 1956</p>	
<p>NAME OF DECEASED JAMES EARL RAY</p>		<p>AGE 35</p>	
<p>SEX Male</p>		<p>RACE White</p>	
<p>DATE OF BIRTH MAY 18 1921</p>		<p>PLACE OF BIRTH Memphis, Tennessee</p>	
<p>EDUCATION High School Graduate</p>		<p>OCCUPATION Author</p>	
<p>RELIGION Methodist</p>		<p>US CITIZENSHIP Naturalized</p>	
<p>DATE OF DEATH JUN 13 1956</p>		<p>PLACE OF DEATH Baltimore, Maryland</p>	
<p>CAUSE OF DEATH Suicide</p>		<p>MANNER OF DEATH Homicide</p>	
<p>IMMEDIATE CAUSE OF DEATH Shot</p>		<p>UNDERLYING CAUSE OF DEATH Suicide</p>	
<p>DATE OF DEATH JUN 13 1956</p>		<p>PLACE OF DEATH Baltimore, Maryland</p>	
<p>CAUSE OF DEATH Suicide</p>		<p>MANNER OF DEATH Homicide</p>	
<p>IMMEDIATE CAUSE OF DEATH Shot</p>		<p>UNDERLYING CAUSE OF DEATH Suicide</p>	

RECEIVED
JUN 13 1956
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6669 CERTIFICATE OF DEATH

66654

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 3 mos	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Sanitarium		d. STREET ADDRESS State Street	
3. NAME OF DECEASED (Type or print) First Nancy Middle Hastings Last Hastings		4. DATE OF DEATH Month June Day 8 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov, 4, 1869
9. AGE (In years 86 birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Archielus Hastings	
14. MOTHER'S MAIDEN NAME May Rue		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Earl Hastings, Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Carcinoma of the Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cornary Thrombosis DUE TO (c) General Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 months 15 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 56 , to June 8 , 19 56 , that I last saw the deceased alive on JUNE 8 , 19 56 , and that death occurred at 12:30 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip A. Insley M.D.		ADDRESS (Street, city or town, state) Delmar, Md	
PHYSICIAN'S NAME (Type) Philip A. Insley		DATE SIGNED	
22a. BURIAL, CREMATION, REMAINS (Specify) Burial		22b. DATE THEREOF 6-11-56	
22c. NAME OF CEMETERY OR INTERMENT Smith Mills		22d. LOCATION (City, town, or county) (State) Delmar, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Marvel Co - Delmar, Del ADDRESS		24a. REC'D BY REGISTRAR DATE 6-13-56	
24b. REGISTRAR'S SIGNATURE May W. Holloway			

1956 JUN 13

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1.
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6795
CERTIFICATE OF DEATH

06655

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 5 (Glen Rd)				d. STREET ADDRESS R.D.# 5 (Glen Rd)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) OLLIE ATMORE HITCHENS				4. DATE OF DEATH Month JUNE Day 2nd Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1891		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refinishing Furniture - Furniture				10b. KIND OF BUSINESS OR INDUSTRY Melsons Maryland		11. BIRTHPLACE (State or foreign country) U S A	
13. FATHER'S NAME Daniel Atmore Hitchens				14. MOTHER'S MAIDEN NAME Mahala Maddox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Lillie V. Hitchens (Wife) Address R.D.# 5 (Glen Rd) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatous 1421 DUE TO Carcinoma of Parotid Gland. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-24 , 19 56 , to 6-2 , 19 56 , that I last saw the deceased alive on 5-24 , 19 56 , and that death occurred at 3:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Camden Ave. DATE SIGNED June 4 1956 ACTUAL SIGNATURE Earl L Royer M.D. PHYSICIAN'S NAME (Type) Dr. Earl L. Royer M.D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 4, 1956		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND				24a. REC'D BY REGISTRAR DATE 6-5-56		24b. REGISTRAR'S SIGNATURE Mary J. Holloway	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
MARRIAGE		DATE		PLACE		NAME		DATE		PLACE	
MARRIED		1950		MEMPHIS, TENN.		JANE RAY		1950		MEMPHIS, TENN.	
OCCUPATION		DATE		PLACE		NAME		DATE		PLACE	
CONTRACTOR		1950		MEMPHIS, TENN.		JANE RAY		1950		MEMPHIS, TENN.	
CAUSE OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
HEART DISEASE		1968		MEMPHIS, TENN.		JANE RAY		1968		MEMPHIS, TENN.	
MANNER OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
NATURAL		1968		MEMPHIS, TENN.		JANE RAY		1968		MEMPHIS, TENN.	
CERTIFIED BY		DATE		PLACE		NAME		DATE		PLACE	
J. EDWARD BROWN		1968		MEMPHIS, TENN.		JANE RAY		1968		MEMPHIS, TENN.	

*James Earl Ray
Contractor of Federal Building*

BUREAU V. 2

JUN 5 1968

RECEIVED

James Earl Ray

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6670

CERTIFICATE OF DEATH

66656

Reg. Dist. No. 360332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 5 1/2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rebecca Middle Elizabeth Last Hoffman				4. DATE OF DEATH Month June Day 8 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1871	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Johnson				14. MOTHER'S MAIDEN NAME Betty Ann Marsh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 1 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 17 , 19 50 , to June 8 , 19 56 , that I last saw the deceased alive on June 7 , 19 56 , and that death occurred at 2:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 6/8/56 ACTUAL SIGNATURE L. V. Maldve M.D. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 10, 1956		22c. NAME OF CEMETERY OR CRYPTORY Asbury Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Vernon, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Newman ADDRESS Princess Anne, Md.				24a. REC'D BY REGISTRAR 6/11/56		24b. REGISTRAR'S SIGNATURE Mary Holloway	

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6671

CERTIFICATE OF DEATH

06657

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>327 Camden Ave.</u>		d. STREET ADDRESS <u>327 Camden Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HENRY HARVEY HATFIELD HOLDEN</u>		4. DATE OF DEATH <u>June 9 th 19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17, 1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months <u>79</u> Days <u>79</u> Hours <u>79</u> Min. <u>79</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Printer - Employee of Printing Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Michigan</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William J. Holden</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Silvia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unk</u>	
17. INFORMANT <u>Mr. Milton M. Holden (Son)</u> Address <u>Newport, Delaware</u>		17. INFORMANT <u>Mrs. H. Harvey Holden (Wife)</u> Address <u>327 Camden Ave. Salisbury</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u> DUE TO (b) <u>cerebral arteriosclerosis</u> DUE TO (c) <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year. Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 9, 1956</u> to <u>June 9, 1956</u> that I last saw the deceased alive on <u>June 9, 1956</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.		DATE SIGNED <u>June 11 1956</u>	
ACTUAL SIGNATURE <u>Harry Mattax</u> M.D. <u>Camden Ave.</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Harry Mattax</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 12, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME-SALISBURY MD.</u>		24a. REC'D BY REGISTRAR <u>DATE 6-12-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BUREAU OF VITALS

DATE OF DEATH

MADE IN

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

BUREAU V. S.

JUN 12 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6672

CERTIFICATE OF DEATH

66658

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 5/13/55</u>		TOWN <u>Salisbury</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				<u>Delmar Road, R. F. D. #5</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Samuel</u> (Middle) <u>Earl</u> (Last) <u>Holt</u>				(Month) <u>June</u> (Day) <u>22</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 4, 1879</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
					Months <u>6</u> Days <u>18</u>	Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Worked on Boat</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Holt</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Sommers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Deceased on admission to hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
002X IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chc Myocarditis</u>				<u>10 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 13</u> , 19 <u>55</u> , to <u>June 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 22</u> , 19 <u>56</u> , and that death occurred at <u>6</u> <u>a.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>S. H. Hurdler</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>6/22/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jun. 24, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>June 23 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Co Salisbury Md.</u> ADDRESS			

[illegible]

JUN 25 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6706

CERTIFICATE OF DEATH

Reg. Dist. No. 332

06659

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron		c. LENGTH OF STAY IN 1b 50 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Church Street		d. STREET ADDRESS Church Street	
3. NAME OF DECEASED (Type or print) First Elfa Middle E. Last Howard		4. DATE OF DEATH Month June Day 11 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1869
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Sussex County, Del.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wilson Baker		14. MOTHER'S MAIDEN NAME Augusta Knowles,	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Wilson Howard, Hebron, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 5th , 19 56 , to June 10th , 19 56 , that I last saw the deceased alive on June 10th , 19 56 , and that death occurred at 7:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William E. Smith		DATE SIGNED June 11-56	
PHYSICIAN'S NAME (Type)		ADDRESS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-56	
22c. NAME OF CEMETERY OR CREMATORY Hebron		22d. LOCATION (City, town, or county) (State) Hebron, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Garmel Co - Baltimore, Md.		24a. REC'D BY REGISTRAR DATE 6-14-56	
24b. REGISTRAR'S SIGNATURE May R. Holloway			

CERTIFICATE OF DEATH

NAME OF DECEASED William Henry		DATE OF BIRTH June 21, 1883		PLACE OF BIRTH England	
SEX Male		AGE 40 yrs		RACE White	
DATE OF DEATH June 21, 1923		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease	
TIME OF DEATH 10:00 AM		MANNER OF DEATH Natural		DISEASE OR INJURY Coronary Artery Disease	
SIGNATURE OF DECEASED William Henry		SIGNATURE OF WITNESS James Smith		SIGNATURE OF PHYSICIAN Dr. J. H. Smith	
DATE OF SIGNATURE June 21, 1923		DATE OF SIGNATURE June 21, 1923		DATE OF SIGNATURE June 21, 1923	

RECEIVED
JUN 14 1923
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6673

CERTIFICATE OF DEATH

06660

Reg. Dist. No. 322

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 3 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 114 Walston Ave		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
4. DATE OF DEATH Month June Day 13 Year 1956		d. STREET ADDRESS 114 Walston Ave	
3. NAME OF DECEASED (Type or print) First JOHN Middle WESLEY Last HYNSON		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1873
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Watchman	11. BIRTHPLACE (State or foreign country) Talbot Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME John Hynson	
14. MOTHER'S MAIDEN NAME Roxanna Tarbutton		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. John P. Hynson (Son) Address 114 Walston Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Congestive Heart Failure DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 mon.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour 0 p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb. 1956 , to 6-13-56 , 19____, that I last saw the deceased alive on 6-13-56 , 19____, and that death occurred at 9:45P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Lee Lawry M.D.		PHYSICIAN'S NAME (Type) Dr. Lee Lawry M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 16 1956	
22c. NAME OF CEMETERY OR CREMATORY Silverbrook Cemetery		22d. LOCATION (City, town, or county) (State) Wilmington, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE 6-18-56	
24b. REGISTRAR'S SIGNATURE Mary W. Holloway			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6674 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06661

Reg. Dist. No. 332

Item 2, Film G199 7-5-56 et

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb 12 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Hill Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 1115 Argonne Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Esau Middle Insley Last Insley		4. DATE OF DEATH Month 6 Day 25 Year 19 56	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1880
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 25 Hours 19 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired machinest		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Esau S.D. Insley		14. MOTHER'S MAIDEN NAME Annie Dickey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs David Turner Nanticoke, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic cardio-vascular disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 924.7 DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of left hip with osteomyelitis of the femur. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Fell at the Wilmer Nursing Home.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at the Wilmer Nursing Home.	
20c. TIME OF INJURY Month, Day, Year 3 21 19 56 Hour 3 a. m. 21 p. m. 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Nursing Home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury		20f. (City or town) Salisbury (County) Wicomico (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> contributing.			
ACTUAL SIGNATURE Earl L. Royer EXAMINER'S NAME (Type) Earl L. Royer, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6-26-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF June 27, 1956	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Levin B. Wilson		24a. REC'D BY REGISTRAR 6-27-56	
ADDRESS Princess Anne, Maryland		24b. REGISTRAR'S SIGNATURE Mary W. Halloray	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
REG. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES E. HARRIS		45		M		W		C	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE	
JUN 28 1956		BALTIMORE, MD		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		MILITARY SERVICE	
JAN 15 1911		BALTIMORE, MD		HIGH SCHOOL		LABORER		NONE	
MARRIAGE		SPOUSE		CHILDREN		PREVIOUS ILLNESS		HABIT	
MARRIED		JANE E. HARRIS		2		NONE		SMOKER	
DATE OF MARRIAGE		DATE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		CEREMONY	
JUN 15 1935		JUN 28 1956		JUN 29 1956		BALTIMORE, MD		CATHOLIC	
SIGNATURE OF EXAMINER		DATE		SIGNATURE OF DECEASED		DATE		SIGNATURE OF WITNESS	
J. E. HARRIS		JUN 29 1956		J. E. HARRIS		JUN 29 1956		J. E. HARRIS	

RECEIVED
JUN 29 1956
BUREAU V. S.

6675

66662

CERTIFICATE OF DEATH

Reg. Dist. No. 322

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>May</u> Last <u>Jenkins</u>		4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 4, 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Minous Ruark</u>		14. MOTHER'S MAIDEN NAME <u>Belle Smullen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Hospital Records & Mr. Elisha W. Parker Jr (Son)</u>		Address <u>E. State St. Delmar, Delaware</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Ca. metastasis of abdomen</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Inoperable Ca. of uterus</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease and diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. 19 <u>56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 4, 1953</u> , to <u>June 9, 1956</u> , that I last saw the deceased alive on <u>June 9, 1956</u> , and that death occurred at <u>2:30P M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. V. Juerman</u>		ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>6/9/56</u>	
PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 12, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME—SALISBURY, MD.</u>		24a. REC'D BY REGISTRAR <u>6-12-56</u> 24b. REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>	

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

6676

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Hill</u> 19x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RONALD</u> <u>JOHNSON</u>		4. DATE OF DEATH <u>June</u> <u>5</u> - <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 9, 1955</u>
9. AGE (In years lost birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM FRAZIER JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>Luvenia Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>LUVENIA JOHNSON</u>		Address <u>Upper Hill, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden death</u> DUE TO (b) <u>Pneumonia, Broncho</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CAETINISM</u> DUE TO (b) <u>CAETINISM</u> DUE TO (c) <u>CAETINISM</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____ 21. I certify that I attended the deceased from <u>1 June</u> , 19 <u>56</u> , to <u>5 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5 June</u> , 19 <u>56</u> , and that death occurred at <u>11 A</u> . M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>June 5, 1956</u> ACTUAL SIGNATURE <u>Morris A. Lambdin</u> M.D. <u>707 Camden - Salisbury Md</u> PHYSICIAN'S NAME (Type) <u>Morris A. Lambdin, Salisbury, Md</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-6-56</u> 22b. DATE THEREOF <u>6-6-56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Upper Hill Cemetery</u> 22d. LOCATION (City, town, or county) <u>Upper Hill</u> (State) <u>Md</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Johnson</u> ADDRESS <u>Upper Hill, Md</u> 24a. REC'D BY REGISTRAR <u>6-6-56</u> 24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 10

<p>1. NAME OF DECEASED WILLIAM STONE JR. JAMES A. STONE JR.</p>		<p>2. SEX MALE</p>	
<p>3. AGE 34</p>		<p>4. DATE OF BIRTH 1922</p>	
<p>5. PLACE OF BIRTH NEW BEDFORD, MASS.</p>		<p>6. OCCUPATION LABORER</p>	
<p>7. MARITAL STATUS MARRIED</p>		<p>8. DATE OF MARRIAGE 1948</p>	
<p>9. PLACE OF DEATH HOME</p>		<p>10. DATE OF DEATH 1956</p>	
<p>11. CAUSE OF DEATH HEART DISEASE</p>		<p>12. MANNER OF DEATH NATURAL</p>	
<p>13. SIGNATURE OF PHYSICIAN J. STONE</p>		<p>14. SIGNATURE OF REGISTRAR J. STONE</p>	
<p>15. SIGNATURE OF DECEASED J. STONE</p>		<p>16. SIGNATURE OF WITNESSES J. STONE</p>	

BUREAU V. 3

JUN 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6797

CERTIFICATE OF DEATH

86664

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shad Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shad Point	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1 Salisbury		d. STREET ADDRESS R.D.# 1 Salisbury	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LILLIE Middle BELL Last JONES		4. DATE OF DEATH Month JUNE Day 5 th Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1872
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Work at Home	
11. BIRTHPLACE (State or foreign country) Shad Point (R.D.# Salisbury)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Williams		14. MOTHER'S MAIDEN NAME Charlotte Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Harold Townsend (Daughter) Address Shad Point R.D.# 1 Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Minutes			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 54 , to 6-5- , 19 56 , that I last saw the deceased alive on 6-5- , 19 56 , and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Main St. (Office) DATE SIGNED June 8 1956			
ACTUAL SIGNATURE Philip A. Insley		M.D. Dr. Philip A. Insley M.D.	
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 9, 1956	
22c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery		22d. LOCATION (City, town, or county) (State) R.D.# 1 Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME * SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE 6-11-56	
24b. REGISTRAR'S SIGNATURE Mary Holloway			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF NEXT OF KIN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF CHIEF CLERK [Faint text]		SIGNATURE OF ASSISTANT CLERK [Faint text]		SIGNATURE OF DEPUTY CLERK [Faint text]	

BUREAU V. S.

JUN 11 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6677 CERTIFICATE OF DEATH

66665

Reg. Dist. No. 222

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY OR TOWN <u>Mardella</u> (Rural)		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Penninsula Gen Hosp</u>		STREET ADDRESS <u>Route #3</u>					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Walter</u>		(Middle) <u>Lynch</u>		(Last)		(Month) (Day) (Year)	
5. SEX <u>M</u>		6. COLOR OR RACE <u>A.A.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Unknown</u>		8. DATE OF BIRTH <u>About 1886</u>	
9. AGE last birthday <u>70</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>245 07 8050</u>		17. INFORMANT & ADDRESS <u>Wallet identification</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
157X IMMEDIATE CAUSE (A) <u>Hepatic Insufficiency</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of head of Pancreas</u>				<u>6 mos +</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/18</u> , 19 <u>56</u> , to <u>6/14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/14</u> , 19 <u>56</u> , and that death occurred at <u>3</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Walter S. Gardner Jr.</u> M.D.				ADDRESS (Street, city, town, state) <u>3215 D. St., Salisbury, Md.</u> DATE SIGNED <u>6/16/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>6-16-56</u>		NAME OF CEMETERY OR CREMATORY <u>Hollister Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hollister, N.C.</u>	
24. REC'D BY REGISTRAR <u>Mary W. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary A. Stewart</u> ADDRESS <u>J. F. Stewart Funeral Home, Salisbury, Md.</u>			

JUN 18 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6708 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06666

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mardela</u>			c. LENGTH OF STAY IN 1b <u>3 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mardela</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Albert</u> Middle <u>Malkin</u> Last				4. DATE OF DEATH Month <u>6-19</u> Day <u>19</u> Year <u>56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 29, 1906</u>		9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Manfred Malkin</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Rudie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>405 Address 14th St.</u> <u>Harold Julien Malkin New York City, N.Y.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by hanging.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung himself in barn by the neck.</u>					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Barn</u>		20f. (City or town) <u>Mardela</u> (County) <u>Wicomico</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: <u>Natural causes</u> <input type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Suicide</u> <input checked="" type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined cause</u> <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				DATE SIGNED <u>6-20-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico MEM. PARK</u>		22d. LOCATION (City, town, or county) <u>Salisbury, Maryland</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas F. Walker, Salisbury, Md.</u>				ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR <u>6-20-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>				DATE <u>6-20-56</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6678

CERTIFICATE OF DEATH

66667

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury				c. LENGTH OF STAY IN 1b 4 1/2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 91 Deer's Head State Hospital				d. STREET ADDRESS 7652 RFD # 3 OLD BATTLE GROVE RD			
3. NAME OF DECEASED (Type or print) First Charles Middle Vince Last McElhose				4. DATE OF DEATH Month June Day 18 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/29/1888		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Beverly, Ohio	
13. FATHER'S NAME Samuel McElhose				14. MOTHER'S MAIDEN NAME Lennie Travis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNK. NO				16. SOCIAL SECURITY NO. 194-09-4408		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis obliterans DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 15 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic polyarthritis and pyelonephritis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Nov. 13 , 19 51 , to June 18 , 19 56 , that I last saw the deceased alive on June 18 , 19 56 , and that death occurred at 12:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Juerman				ADDRESS (Street, city or town, state) Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				DATE SIGNED 6/18/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-21-56		22c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE		22d. LOCATION (City, town, or county) (State) HOWARD Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Buckle Buckley, Dundalk, Md				ADDRESS		24a. REC'D BY REGISTRAR DATE 6-21-56	
				24b. REGISTRAR'S SIGNATURE Mary W. Holloway			

BUREAU V. S.

JUN 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6679

CERTIFICATE OF DEATH

66668

Reg. Dist. No. 382

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Route 1 - Box 177</u>			
3. NAME OF DECEASED (Type or print) First <u>Addison</u> Middle <u>Mitchell</u> Last <u>Mitchell</u>				4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Coleored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 4, 1902</u> 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>FIA.</u>	
13. FATHER'S NAME <u>BENJAMIN MITCHELL</u>				14. MOTHER'S MAIDEN NAME <u>CORE LEE ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>266-18-0388</u>		17. INFORMANT Address <u>Rosa Mitchell Pocomoke, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Myocardial infarct, acute</u> DUE TO (b) <u>Arteriosclerotic coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>11</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>uremia due to urethral stricture, acquired</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/7/56</u> , 19 <u>56</u> , to <u>6/18/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Elliot</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>6-19-56</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>6-22-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS, TENN.		JULY 6, 1968		MEMPHIS, TENN.	
MOTHER'S NAME		FATHER'S NAME		MARRIAGE DATE		EDUCATION		OCCUPATION		MILITARY SERVICE		CAUSE OF DEATH		MANNER OF DEATH	
JAMES EARL RAY		JAMES EARL RAY		1950		HIGH SCHOOL		CLOCK REPAIR		U.S. AIR FORCE		HEART DISEASE		NATURAL	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER		PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN		SIGNATURE OF MORTUARY		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

RECEIVED
JUN 25 1968
BUREAU V. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6630

CERTIFICATE OF DEATH

Reg. Dist. No.

06669

332

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b ---	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle HERBERT Last MOORE, SR.,		4. DATE OF DEATH Month June Day 16 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Chemical Eng.		10b. KIND OF BUSINESS OR INDUSTRY Engineer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U?S.A.	
13. FATHER'S NAME G.W. Moore		14. MOTHER'S MAIDEN NAME Lillian Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. 616-05- 8201	
17. INFORMANT 308 Beckford Ave.		Mrs. John L. Bond, Prince Anne, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Longtime of left foot DUE TO (c) Generalized atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH months 5 days yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> b. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:45P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. A. Briele		M.D. Medical Center ADDRESS (Street, city or town, state) 6.18.56 DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. Henry A. Briele. Medical Center, Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/18/56	
22c. NAME OF CEMETERY OR CREMATORY Still Pond Cemetery		22d. LOCATION (City, town, or county) (State) Still Pond, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		ADDRESS Norman T. Baker	
24a. REC'D BY REGISTRAR DATE 6-18-56		24b. REGISTRAR'S SIGNATURE Mary W. Hollonay	

CERTIFICATE OF DEATH

NAME OF DECEASED		LOCALITY	
JAMES EARL RAY		MEMPHIS, TENN.	
DATE OF DEATH		PLACE OF DEATH	
APRIL 4, 1968		MEMPHIS, TENN.	
AGE		OCCUPATION	
35		ATTORNEY	
SEX		CAUSE OF DEATH	
MALE		HEART DISEASE	
RACE		MANNER OF DEATH	
WHITE		NATURAL	
EDUCATION		SPECIAL INQUIRY	
HIGH SCHOOL		NO	
RELIGION		BAPTIST	
MARRIED		SINGLE	
YES		NO	
NAME OF SPOUSE		NAME OF SPOUSE	
JANET EARL RAY		JANET EARL RAY	
DATE OF MARRIAGE		DATE OF MARRIAGE	
APRIL 1964		APRIL 1964	
PLACE OF BIRTH		PLACE OF BIRTH	
MEMPHIS, TENN.		MEMPHIS, TENN.	
DATE OF BIRTH		DATE OF BIRTH	
APRIL 1933		APRIL 1933	
FATHER'S NAME		FATHER'S NAME	
JAMES EARL RAY		JAMES EARL RAY	
MOTHER'S NAME		MOTHER'S NAME	
JANET EARL RAY		JANET EARL RAY	
DATE OF DEATH		DATE OF DEATH	
APRIL 4, 1968		APRIL 4, 1968	
PLACE OF DEATH		PLACE OF DEATH	
MEMPHIS, TENN.		MEMPHIS, TENN.	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
SPECIAL INQUIRY		SPECIAL INQUIRY	
NO		NO	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JANET EARL RAY		JANET EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968	

BUREAU V. S.

JUN 20 1966

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06670
6681 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 882

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>10 Mi.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Camden and Woodland Road</u>				d. STREET ADDRESS <u>224 East Church St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Bounds</u> Last <u>Niblett</u>				4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>19 56</u>			
5. SEX <u>M Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 8, 1905</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Shirt factory</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George Wm. Boundas</u>				14. MOTHER'S MAIDEN NAME <u>Belle Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>220-40-9812</u>		17. INFORMANT Address <u>Rudolph Niblett, Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased driving car involved in two car collision.</u>				
20c. TIME OF INJURY Month, Day, Year <u>9</u> a.m. <u>6-14</u> <u>1956</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		
20f. (City or town) <u>Salisbury</u>			(County) <u>Wicomico</u>		(State) <u>Md.</u>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , <u>Inquiry</u> <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , <u>Accident</u> <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>6-18-56</u>			
22a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		22b. DATE THEREOF <u>6/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Siloan Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Siloan, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u> <u>Norman T. Baker</u>				24a. REC'D BY REGISTRAR DATE <u>6-18-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6682

CERTIFICATE OF DEATH

Reg. Dist. No.

06671

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>RFD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mr. Howard</u> Middle <u>Patey</u> Last <u>Patey</u>				4. DATE OF DEATH Month <u>6/6/56</u> Day <u>19</u> Year <u>19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 3, 1907</u>	9. AGE (In years last birthday) yrs. <u>49</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Herman Patey</u>				14. MOTHER'S MAIDEN NAME <u>Eva Patey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>xxxxx</u>				16. SOCIAL SECURITY NO. <u>222-2877</u> INFORMANT Address <u>Mrs. Martha Patey Willards, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u> </u> , 19 <u>56</u> , to <u> </u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-6</u> , 19 <u>56</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. O. Ellis</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>6-2-56</u>			
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Church</u>		22d. LOCATION (City, town, or county) (State) <u>Willards Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rita Whaley</u>				24a. REC'D BY REGISTRAR DATE <u>6-12-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6683 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06672

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b app: 30min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen. Gen. Hospital				d. STREET ADDRESS 812 East Church St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MELVIN Middle ROBERT Last PHILLIPS				4. DATE OF DEATH Month June Day 28 th 19 Year 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1944		9. AGE (In years last birthday) 11 yrs.	IF UNDER 1 YEAR Months 9 Days 25	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Phillips				14. MOTHER'S MAIDEN NAME Wilsie Mae Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Mr. James E. Phillips (Father) Address 812 East Church St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Riding bike and was involved in collision with road grader.					
20c. TIME OF INJURY Month, Day, Year 1:20 P.M. 6-28 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) On XXXXXX Street		20f. (City or town) (County) (State) Salisbury Wicomico Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Earl L. Royer</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Earl L. Royer M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1956		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME- SALISBURY, MD.				24a. REC'D BY REGISTRAR JUL 2 1956			
				24b. REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
JUL 2 1956
BUREAU V. T.

JUL 2 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6684 CERTIFICATE OF DEATH

66673

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS In Village			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First VIRGIE Middle MAE Last POWELL				4. DATE OF DEATH Month JUNE Day 22 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1902	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months 7 Days 24	IF UNDER 24 HRS. Hours 24 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY At own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME John Robert Bailey				14. MOTHER'S MAIDEN NAME Minnie Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. James W. Powell (Husband)				Address Parsonsbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential hypertension DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Week 8 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6/18 , 19 56 , to 6/22 , 19 56 , that I last saw the deceased alive on 6/21 , 19 56 , and that death occurred at 5:40 A. M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Salisbury, Maryland				DATE SIGNED June 22, 1956			
ACTUAL SIGNATURE Earl Beardsley				M.D. Maryland Ave. (Office)			
PHYSICIAN'S NAME (Type) Dr. Earl Beardsley M.D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 24, 1956		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME—				ADDRESS SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE JUN 25 1956	
24b. REGISTRAR'S SIGNATURE Mary H. Holloway							

CERTIFICATE OF DEATH

NAME OF DECEASED (Print name in full)		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE (In years, months, and days)		DATE OF BIRTH	
PLACE OF BIRTH		PLACE OF DEATH	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY	
PRESENT ADDRESS		DATE OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JURY		SIGNATURE OF JUDGE	
SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR	

RECEIVED
 JUN 25 1956
 BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6799 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66674

Reg. Dist. No. 832

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>			c. LENGTH OF STAY IN 1b <u>05X-2</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sharptown bridge</u>				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Quails</u> Last <u>Jr.</u>				4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>19 56</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>About 1924</u>		9. AGE (In years last birthday) <u>32</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Quails</u>				14. MOTHER'S MAIDEN NAME <u>Tisia Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-18-2005</u>		17. INFORMANT Address <u>Ernest Quails, Seaford, Delaware, R.F.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drove car off open drawbridge at Sharptown through barricade.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>9 P</u> a. m. <u>6-16-56</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>drawbridge</u>		20f. (City or town) (County) (State) <u>Sharptown</u> <u>Wicomico</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6-18-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 19, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frempton and Son, Federalsburg, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>6-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollenay</u>	

MEDICAL CERTIFICATION

22

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the funeral home. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to blurring and bleed-through from the reverse side.

BUREAU V. S.

JUN 21 1956

RECEIVED

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6685

CERTIFICATE OF DEATH

06675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital				d. STREET ADDRESS In Village			
3. NAME OF DECEASED (Type or print) First CORA Middle CAROLINE Last RAYNE				4. DATE OF DEATH Month JUNE Day 5 Year th 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 15, 1874	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 11 Days 20 Hours Min. 		10. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (State or foreign country) R.D.# Snow Hill Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired House Work				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Benjamin Jones				14. MOTHER'S MAIDEN NAME Sarah Grace Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Mr. Harry Rayne(Son) Willards, Maryland Mr. Lester Rayne(Son) Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 443X DUE TO CEREBRO VASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO YEARS (c) 						INTERVAL BETWEEN ONSET AND DEATH 18 hours 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) 				20g. (County) 		20h. (State) 	
21. I certify that I attended the deceased from 8/10/1954 to 6/5/1956 , that I last saw the deceased alive on 6/4/1956 , and that death occurred at 7:00A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Maryland Ave. -Office- DATE SIGNED June 5 1956							
ACTUAL SIGNATURE Dr. O.J. Burton M.D.				M.D. Salisbury, Maryland			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 7, 1956		22c. NAME OF CEMETERY OR CREMATORY Pleasant Mt. Pleasant Cemetery		22d. LOCATION (City, town, or county) (State) R.D.# Powellville, Maryland R.D.# Willards, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				24a. REC'D BY REGISTRAR June 6 1956 DATE Mary H. Holloway			
ADDRESS SALISBURY MARYLAND				24b. REGISTRAR'S SIGNATURE			

9561 9 NNR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6710
CERTIFICATE OF DEATH

06676

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. #1				d. STREET ADDRESS Rt. #1			
3. NAME OF DECEASED (Type or print) First ELIJAH Middle QUINTON Last RILEY				4. DATE OF DEATH Month 6 Day 13 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 24, 1864	
9. AGE (In years last birthday) 91 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME James D. Riley			
14. MOTHER'S MAIDEN NAME Hannah Bethard				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. Howard Johnson, Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis, generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic pneumonia R. + L.				INTERVAL BETWEEN ONSET AND DEATH 4 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 1953 , to 6-11 , 19 56 , that I last saw the deceased alive on 6-11 , 19 56 , and that death occurred at 11 40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE [Signature] M.D.				PHYSICIAN'S NAME (Type) Dr. L.V. Sohler 303 East St., Delmar Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/56		22c. NAME OF CEMETERY OR CREMATORY Parsonburg Cemetery		22d. LOCATION (City, town, or county) (State) Parsonburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co., Salisbury, Maryland Norman T. Baker				24a. REC'D BY REGISTRAR 6-14-56		24b. REGISTRAR'S SIGNATURE Mary W. Hollonay	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06677

6686

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>				c. LENGTH OF STAY IN 1b <u>11 Mo. 13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Percy</u> Middle <u>Roberts</u> Last <u>Roberts</u>				4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 16, 1938</u>	
9. AGE (In years from birthday) yrs. <u>17</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u> Hours <u>56</u>		IF UNDER 24 HRS. Months <u>17</u> Days <u>19</u> Hours <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Elmore Roberts</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Stansbury</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic heart disease</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>8 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>July 11, 1955</u> , to <u>June 24, 1956</u> , that I last saw the deceased alive on <u>June 24, 1956</u> , and that death occurred at <u>6:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>6/24/56</u> ACTUAL SIGNATURE <u>L. V. Maldve</u> M.D. <u>L. V. Maldve, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-27-56</u>		<u>Broad Neck</u>		<u>Skidmore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Williams Reese II</u>				ADDRESS <u>108 W. Washington St.</u>		24a. REC'D BY REGISTRAR <u>DATE 27 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 882

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 831 Cooper St		d. STREET ADDRESS 831 Cooper St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First META Middle CLARICE Last SHOCKLEY		4. DATE OF DEATH Month JUNE Day 14 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1896
9. AGE (In years last birthday) yrs. 59		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at own home	
11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Grant Bedsworth		14. MOTHER'S MAIDEN NAME Isabelle Webster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Ira O. Shockley (Husband)		Address 831 Cooper St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Sudden
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 19 52 to 6/14 1956 , that I last saw the deceased alive on 6/14/56 , and that death occurred at 4:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) S. Division St DATE SIGNED June 17 1956			
ACTUAL SIGNATURE Fred R. Granse M.D.		DATE SIGNED June 17 1956	
PHYSICIAN'S NAME (Type) Dr. Fred R. Granse M.D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 17, 1956	22c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME-- SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE 6-19-56	24b. REGISTRAR'S SIGNATURE May W. Holloway

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6551 81 NOV

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66679

6689

CERTIFICATE OF DEATH

Reg. Dist. No. 322

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELEWARE</u> b. COUNTY <u>SUSSEY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEAFORD</u> <u>46X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>RD#1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN NMI SPARKS</u>				4. DATE OF DEATH Month Day Year <u>JUNE 9 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 5, 1915</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM OWNER</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>WILLIAM REESE SPARKS</u>				14. MOTHER'S MAIDEN NAME <u>ETTA SARAH LOVELACE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MRS. ROSE S. BROWN - FEDERALSBURG MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>342X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brain Abscess</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>6/7</u> , 19 <u>56</u> , to <u>6/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6/9</u> , 19 <u>56</u> , and that death occurred at <u>11:47 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>224 N. Division St. Salisbury, Md.</u> DATE SIGNED <u>6/11/56</u>							
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>THOMAS C. HILL JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>MEDFORD L. WATSON JR.</u>				ADDRESS <u>SEAFORD, DELAWARE</u>		24a. REC'D BY REGISTRAR DATE <u>6-13-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

CERTIFICATE OF DEATH

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE 18

NAME: WHITE, JOHN
 DATE OF BIRTH: JULY 2, 1912
 SEX: M
 RACE: W
 OCCUPATION: FARM OWNER
 RESIDENCE: FARM, VIRGINIA
 DECEASED: WILLIAM REESE SPARKS
 CAUSE OF DEATH: ETTA SARAH LOVELACE
 MEDICAL ATTENDANT: MRS REESE BROWN - FEDERAL BUREAU OF INVESTIGATION

BUREAU V. 2

JUN 13 1956

RECEIVED

MEDFORD WATSON JR. SEVERO, DELAWARE
 EXPIRY DATE: JUNE 13, 1956
 FEDERAL BUREAU OF INVESTIGATION

THOMAS C. HILL JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6688 Item 9 Film G204 9-28-56 et
CERTIFICATE OF DEATH

07723
Reg. Dist. No. 331

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>			d. STREET ADDRESS <u>KING STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>SPRIEL</u> Last <u>SPRIEL</u>			4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1899</u>	9. AGE (In years, months, and days) <u>55 Yrs. 9 Mos. 10 days</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>10</u> Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Monticello Md</u>	
13. FATHER'S NAME <u>John Wallace</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
14. MOTHER'S MAIDEN NAME <u>Georgie Dennis</u>			17. INFORMANT <u>Helen Halbrook</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>249-34-2445</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>175X</u> DUE TO <u>Shamtion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ovarian Carcinoma</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____					
ACTUAL SIGNATURE <u>Ostorne Christensen</u> M.D. _____					
PHYSICIAN'S NAME (Type) <u>OSTORNE CHRISTENSEN</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>1-21-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker Wolcott</u>			ADDRESS <u>Salisbury Md</u>		24a. REC'D BY REGISTRAR DATE <u>7-5-56</u>
			24b. REGISTRAR'S SIGNATURE <u>Mary W. Halbrook</u>		

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO.

NAME

AGE

SEX

RACE

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Place of Death

Time of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of County Clerk

Signature of Mayor

Signature of Town Clerk

Signature of Justice of the Peace

Signature of Notary Public

Signature of Minister of the Gospel

Signature of School Teacher

Signature of Fireman

Signature of Police Officer

Signature of Constable

Signature of Sheriff

Signature of Jailor

Signature of Prisoner

Signature of Watchman

Signature of Night Watchman

Signature of Day Watchman

Signature of Night Watchman

BUREAU V. S.

JUL 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6690

CERTIFICATE OF DEATH

Reg. Dist. No. 06680 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virginia Middle Alice Last Stafford		4. DATE OF DEATH Month June Day 12 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/3/1876
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 5 Hours x Min. 2	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Pratt		14. MOTHER'S MAIDEN NAME Sirena Anne Dukes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) 5-6 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 11, 1956 , to June 12, 1956 , that I last saw the deceased alive on June 12, 1956 , and that death occurred at 3:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 6/12/56 ACTUAL SIGNATURE L. V. Maldve M.D. Deer's Head State Hospital PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF June 15/56	
22c. NAME OF CEMETERY OR CREMATORY Denton		22d. LOCATION (City, town, or county) (State) Denton Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. V. Moore		ADDRESS Son	
24a. REC'D BY REGISTRAR DATE 6/15/56		24b. REGISTRAR'S SIGNATURE Don J. Groom	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. S.

JUN 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6691 CERTIFICATE OF DEATH

Reg. Dist. No. 322

66681

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL</u> 23X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address), OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>R. 7. D #2.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DONNELL</u> Middle <u>STEVENSON</u> Last <u>STEVENSON</u>				4. DATE OF DEATH <u>June 9 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 7-1956</u>	
9. AGE (In years last birthday) yrs. <u>46</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Kendal Price</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA Lee STEVENSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>BARBARA STEVENSON</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Electrocardia, bilateral</u> <u>762.5</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Exposure (delivered in car 20 mi from hospital) Traumatic Breach</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Delivery</u> 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							INTERVAL BETWEEN ONSET AND DEATH
21. I certify that I attended the deceased from <u>7 June</u> , 19 <u>56</u> , to <u>9 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9 June</u> , 19 <u>56</u> , and that death occurred at <u>12 Noon</u> M, from the causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE <u>Robert H. Saunders</u> M.D.				ADDRESS (Street, city or town, state) <u>926 N. Division St. Salisbury</u> DATE SIGNED <u>11 June 56</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6/11/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital, Salisbury, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital, Salisbury, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE 6-11-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6692

CERTIFICATE OF DEATH

06682

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNT Somerset	
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (in this place) 2 months		CITY (If outside corporate limits, write RURAL and give nearest town) Princess Anne		TOWN Princess Anne	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) Beckford Ave			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Rachel (Middle) Done (Last) Stewart				(Month) June (Day) 9 (Year) 19 56			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH April 7, 1870	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Princess Anne, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dr. William Stewart				14. MOTHER'S MAIDEN NAME Henrietta Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Mary D. Fitzgerald			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
153x IMMEDIATE CAUSE (A) Carcinoma Colon							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 8, 1956 , to June 9, 1956 , that I last saw the deceased alive on June 8, 1956 , and that death occurred at 10:15 AM , from the causes and on the date stated above.							
SIGNATURE Theresa Lush		M. D. Salisbury Md		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 11, 1956		NAME OF CEMETERY OR CREMATORY St. Andrews Cemetery		LOCATION (City, town, or county) (State) Princess Anne, Maryland	
24. REC'D BY REGISTRAR DATE 6-20-56		REGISTRAR'S SIGNATURE Mary W. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE Levin B. Wilson		ADDRESS Princess Anne, Md	

CERTIFICATE OF DEATH

NAME OF DECEASED: William Steward
AGE: 38 years
SEX: Male
RACE: White
DATE OF DEATH: April 7, 1956
PLACE OF DEATH: Baltimore, Md.

RESIDENCE: 1115 St. Andrews Cemetery, Baltimore, Md.
OCCUPATION: Housewife
CAUSE OF DEATH: (illegible)

DATE OF BIRTH: (illegible)
PLACE OF BIRTH: (illegible)
MARRIAGE: (illegible)

DECEASED'S SIGNATURE: (illegible)
WITNESSES: (illegible)

DECEASED'S SIGNATURE: (illegible)
WITNESSES: (illegible)

DECEASED'S SIGNATURE: (illegible)
WITNESSES: (illegible)

DECEASED'S SIGNATURE: (illegible)
WITNESSES: (illegible)

DECEASED'S SIGNATURE: (illegible)
WITNESSES: (illegible)

DECEASED'S SIGNATURE: (illegible)
WITNESSES: (illegible)

BUREAU V. S.

JUN 21 1956

RECEIVED

JUNE 11, 1956 St. Andrews Cemetery, Baltimore, Md.

Burial

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6693 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>3 year s</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Patrick Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>James</u> Middle <u>Taylor</u> Last				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1923</u>	9. AGE (In years last birthday) <u>33</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Dilmor md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Rogers Taylor</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-12-1444</u>		17. INFORMANT Address <u>Hospital Record, P.G.H. Salisbury Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage into Pericardial and Pleural Cavities</u> DUE TO <u>982x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stab wound of Pulmonary Artery</u> DUE TO (c) <u>minutes</u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Kendrick Mc Gullough</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Kendrick Mc Gullough, M.D., acting</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6-6-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lenox Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Dilmor md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Doan M. West</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>6-9-56</u>	24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>

STATE OF TEXAS DEPARTMENT OF HEALTH-SANITARIAN MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUN 12 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06684

6711

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. # 1 (Union Rd)				d. STREET ADDRESS R.D. # 1 (Union Rd)			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First OLGA Middle ROSE Last THEODORE				4. DATE OF DEATH Month JUNE Day 20 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1886	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Danzig, Germany		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY at own Home		13. FATHER'S NAME (Unk) Mitush	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Nicholas Theodore (Husband) R.D. # 1 Union Rd Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 wks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 19, 1956 to June 20, 1956 , that I last saw the deceased alive on June 19, 1956 , and that death occurred at 12:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Lee Lawry M.D.				DATE SIGNED June 20 1956			
PHYSICIAN'S NAME (Type) Dr. Lee Lawry M.D.				ADDRESS (Street, city, town, state) Fruitland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1956		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME—SALISBURY, MD.				24a. REC'D BY REGISTRAR DATE 6-21-56		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6694

CERTIFICATE OF DEATH

06685

Reg. Dist. No. 322

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>518 E. Isabella St</u>				d. STREET ADDRESS <u>518 E. Isabella St</u>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>BURKE</u> Last <u>THURSTON</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>14</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 24, 1868</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None Retired House Keeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
13. FATHER'S NAME <u>Chastine F. Coleman</u>				14. MOTHER'S MAIDEN NAME <u>Julia Jordan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mr. Walter C. Thurston Jr. (Son)</u> <u>518 E. Isabella St. Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				(County) <u> </u>			
(State) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>6-14, 1955</u> to <u>6-14, 1956</u> that I last saw the deceased alive on <u>6-14, 1956</u> , and that death occurred at <u>5:30 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>June 15 1956</u>							
ACTUAL SIGNATURE <u>Dr. David J. Gilmore M.D.</u>				M.D. <u>Medical Center</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Wilber Ellis M.D.</u>				<u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 17, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Churchland Cemetery</u>		22d. LOCATION (City, town, or county) <u>Near Portsmouth, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY FUNERAL HOME—SALISBURY MD.</u>				24a. REC'D BY REGISTRAR DATE <u>6-18-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

CERTIFICATE OF DEATH

6601

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CORONER	
JAMES EARL RAY		M		35		1928		MEMPHIS, TENN.		ATTORNEY AT LAW		SINGLE		HEART DISEASE		NATURAL		J. EARL RAY		J. EARL RAY		J. EARL RAY	
13. PLACE OF DEATH		14. DATE OF DEATH		15. TIME OF DEATH		16. SEX OF DECEASED		17. AGE OF DECEASED		18. OCCUPATION OF DECEASED		19. MARITAL STATUS OF DECEASED		20. CAUSE OF DEATH		21. MANNER OF DEATH		22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF CORONER	
MEMPHIS, TENN.		4/4/68		10:00 AM		M		35		ATTORNEY AT LAW		SINGLE		HEART DISEASE		NATURAL		J. EARL RAY		J. EARL RAY		J. EARL RAY	
25. PLACE OF DEATH		26. DATE OF DEATH		27. TIME OF DEATH		28. SEX OF DECEASED		29. AGE OF DECEASED		30. OCCUPATION OF DECEASED		31. MARITAL STATUS OF DECEASED		32. CAUSE OF DEATH		33. MANNER OF DEATH		34. SIGNATURE OF REGISTRAR		35. SIGNATURE OF PHYSICIAN		36. SIGNATURE OF CORONER	
MEMPHIS, TENN.		4/4/68		10:00 AM		M		35		ATTORNEY AT LAW		SINGLE		HEART DISEASE		NATURAL		J. EARL RAY		J. EARL RAY		J. EARL RAY	

BUREAU V. 51

JUN 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6695
CERTIFICATE OF DEATH

06686

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 3 wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riverside Nursing Home 409 Camden Court				d. STREET ADDRESS W. Central Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First J. Frank Todd Middle Last				4. DATE OF DEATH Month June Day 18 Year 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1861	
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer & merchant				10b. KIND OF BUSINESS OR INDUSTRY Caroline Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jehu Todd				14. MOTHER'S MAIDEN NAME Henryetta Sutherland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Louise F. Todd Federalsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/14 , 19 56 , to 6/18 , 19 56 , that I last saw the deceased alive on 6/18 , 19 56 , and that death occurred at 9:30 a. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE F. R. Gramse M.D. Salisbury, Md. PHYSICIAN'S NAME (Type) Fred R. Gramse, M.D. Salisbury, Md. 6-21-56							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF June 21, 1956		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.		22d. LOCATION (City, town, or county) (State) Federalsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey Williams ADDRESS Federalsburg, Md.				24a. REC'D BY REGISTRAR DATE 6-25-56		24b. REGISTRAR'S SIGNATURE Mary W. Holloway	

2000

1007-1012

22

2.2.2

BUREAU V.

JUN 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6696 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06687

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>4 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>RFD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rufus</u> Middle <u></u> Last <u>Truitt</u>				4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>19 56</u>		5. SEX <u>M</u> <u>W</u>	
6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>May 9 1924</u>		9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of last year, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>James R. Truitt</u>				14. MOTHER'S MAIDEN NAME <u>Mildred V. Bradford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, X unknown) <u>X</u>		16. SOCIAL SECURITY NO. <u>218-16-5753</u>		17. INFORMANT <u>James R. Truitt</u> Address <u>Willards, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of cervical spine</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Deceased was driving car that struck a culvert RFD # 374</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Deceased was driving car that struck a culvert RFD # 374</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>6-10</u> 19 <u>56</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Hearderslin</u> <u>Wicomico</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-15-56</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Willards</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley</u>				24a. REC'D BY REGISTRAR <u>6-18-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John F. Smith		45		Male		White		June 19, 1956		Boston, Mass.	
Cause of Death		Disease		Injury		Poison		Other		Remarks	
Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Diabetes Mellitus		Chronic Bronchitis		No autopsy performed	
Physician's Signature		Physician's Name		Physician's Address		Physician's City		Physician's State		Physician's Zip	
[Signature]		John F. Smith		123 Main St.		Boston		Mass.		02101	
Medical Examiner's Signature		Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's City		Medical Examiner's State		Medical Examiner's Zip	
[Signature]		John F. Smith		123 Main St.		Boston		Mass.		02101	

BUREAU V. S.

JUN 19 1956

RECEIVED

[Handwritten signature]

CERTIFICATE OF DEATH

Reg. Dist. No. 332

6712

1. PLACE OF DEATH

COUNTY Wicomico
CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN NanticokeMARYLAND
LENGTH OF STAY
(in this place)
LifetimeHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN Nanticoke

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED
(Type or Print)

(First)

(Middle)

(Last)

LucyJaneWalter

4. DATE OF DEATH

(Month)

(Day)

(Year)

June 1619 56

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

FWSingleAug. 3, 187679

yrs.

1013

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Home Demonstration Agent (ExtensionNanticoke, MarylandU.S.

13. FATHER'S NAME

service)

14. MOTHER'S MAIDEN NAME

Levin Thomas WalterEmily S. Evans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

NoLevin Walter, Nanticoke, Maryland

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A)
ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO
(C)Acute Coronary Occlusion
Arteriosclerotic Heart Disease1 hour
5 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5:23, 1956, to 6:16, 1956, that I last saw the deceased alive on 6/16, 1956, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE 6-22-56Mary W. HollowayC. H. Messitt, Bivalve, Maryland

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

File No. 100

LOCAL RESIDENT OR PLACE OF BIRTH

PLACE OF DEATH

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH

DATE OF DEATH
 PLACE OF DEATH

CAUSE OF DEATH
 MANNER OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

DATE OF DEATH
 PLACE OF DEATH

BUREAU V. 1

JUN 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6697

CERTIFICATE OF DEATH

Reg. Dist. No.

66689

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>Worcester</u> <u>Maryland</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PHILADELPHIA</u> <u>Pocomoke</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>75X-3</u>		d. STREET ADDRESS <u>R.R. #2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth F. Waters</u>				4. DATE OF DEATH Month Day Year <u>June 22-1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13-1956</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>1 11</u>		IF UNDER 24 HRS. <u>1 11</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Edward Walters</u>				14. MOTHER'S MAIDEN NAME <u>Delosier Yancey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Edward Walters Pocomoke Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lower nephron nephrosis</u> DUE TO <u>Septicemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>591X</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>6-19-1956</u> to <u>6-22-1956</u> that I last saw the deceased alive on <u>6-22-1956</u> , and that death occurred at <u>8:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>Morris C. Lambdin</u> M.D.							
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Unionville Cem Pocomoke Md</u>		22d. LOCATION (City, town, or county) (State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Watson</u> (Pocomoke Md)				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>	

CERTIFICATE OF DEATH

0001

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF BIRTH: *Jan 15 1910*

5. PLACE OF BIRTH: *John Doe, Md.*

6. OCCUPATION: *Farmer*

7. CAUSE OF DEATH: *Heart Disease*

8. DATE OF DEATH: *June 10 1956*

9. PLACE OF DEATH: *John Doe, Md.*

10. SIGNATURE OF PHYSICIAN: *John Doe, M.D.*

11. SIGNATURE OF REGISTRAR: *John Doe*

12. SIGNATURE OF WITNESSES: *John Doe, John Doe*

RECEIVED
JUN 25 1956
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6698 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06690
332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sandy Hill Beach</u>				d. STREET ADDRESS <u>R F D # 1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Norman Whaley</u>				4. DATE OF DEATH Month Day Year <u>6 17 19 56</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Partner Home Service Oil</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delaware</u>		9. AGE (In years last birthday) <u>35</u> yrs.			
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John W. Whaley</u>				14. MOTHER'S MAIDEN NAME <u>Emma Hudson Whaley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 		17. INFORMANT <u>Ignacio Whaley Salisbury Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found floundering in water face down at Sandy Hill Beach.</u>					
20c. TIME OF INJURY Month, Day, Year <u>4:45 a.m. 6-17-19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Beach</u>			
20f. (City or town) <u>Salisbury</u>		(County) <u>Wicomico</u>		(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6-20-56</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>6-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) <u>Delaware</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson + Gray Frankfurt Ida.</u>		24a. REC'D BY REGISTRAR <u>DATE 6-26-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUN 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6699

CERTIFICATE OF DEATH

66691

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>21 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mardela</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARIA</u> Middle <u>ELLEN</u> Last <u>Waller</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 10, 1885</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>		IF UNDER 24 HRS. Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>WICOMICO CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>HENRY HUTT</u>				14. MOTHER'S MAIDEN NAME <u>HENNIE (MAIDEN NAME UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>UNKNOWN</u>		17. INFORMANT Address <u>MRS. CATHERINE THOMAS - MARDELA MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 391X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June 11, 1956</u> , to <u>June 29, 1956</u> , that I last saw the deceased alive on <u>June 29, 1956</u> , and that death occurred at <u>2:50 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andrew C. Mitchell</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>6-29-56</u>			
PHYSICIAN'S NAME (Type) <u>ANDREW C. Mitchell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. NEBO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR DELMAR, DELAWARE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton</u> ADDRESS <u>Box, Federalsburg, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 7-2-56</u>		24b. REGISTRAR'S SIGNATURE <u>Maryell Holloway</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

0000

RECEIVED
JUL 5 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6713 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06692

Reg. Dist. No. 332

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sharptown drawbridge</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finchville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Henry Williams Jr.</u>				4. DATE OF DEATH Month Day Year <u>6 16 19 56</u>													
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 22, 1949</u>		9. AGE (In years last birthday) <u>6</u> yrs. <table border="1" style="display: inline-table; width: 100%;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Charles H. Williams</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lee Tilghman</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Charles H. Williams, Federalsburg, Md. R.F.D.</u>													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>824x</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in car that ran off open drawbridge through barricade.</u>													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>9 P 6-16 19 56</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Drawbridge</u>		20f. (City or town) <u>Sharptown</u> (County) <u>Wicomico</u> (State) <u>Md.</u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>Earl L. Royer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>6-18-56</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 21, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>				24a. REC'D BY REGISTRAR <u>6-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
PLACE OF BIRTH		OCCUPATION		EDUCATION		MARRIAGE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY		PREVIOUS ILLNESS		TREATMENT	
FAMILY HISTORY		SOCIAL HISTORY		HABITS		OTHER	
SIGNATURE OF EXAMINER		DATE		PLACE		TITLE	

BUREAU V. S.

JUN 21 1956

RECEIVED

[Handwritten signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6714

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06693

332

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finchville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sharptown drawbridge</u>		d. STREET ADDRESS <u>094-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Lee</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>6-16-</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1914</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Tilghman</u>		14. MOTHER'S MAIDEN NAME <u>Rosealee Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Charles H. Williams, Federalsburg, Md.</u>		Address <u>R.F.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in car that went through barricade of open drawbridge.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9 P</u> a. m. <u>6-16</u> 19 <u>56</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sharptown drawbridge. Sharptown Wicomico Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6-18-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 21, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u>DATE 6-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mary W. Hollonay</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes fields for name, age, sex, race, date of death, and place of death. The form is partially filled out with handwritten and printed text.

BUREAU V. S.

JUN 21 1956

RECEIVED

Handwritten signature

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06694

67-0 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2, Film G199 6-22-56 et.

Reg. Dist. No.

776332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 2 1/2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deers Head Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Norman Middle Lee Last Wrightson		4. DATE OF DEATH Month 6 Day 5 Year 19 56	
5. SEX M W	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1894
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME J. Alonza Wrightson		14. MOTHER'S MAIDEN NAME Victoria Ewell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Helen Jones, 112 Cemetery Ave., Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema of lungs and brain 223X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Neurofibroma of cerebellum DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Minutes Months		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		DATE SIGNED 6-14-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 7, 1956	
22c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery		22d. LOCATION (City, town, or county) (State) East New Market, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Llewellyn R. Thomas		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR DATE June 7, 1956		24b. REGISTRAR'S SIGNATURE John R. S.	

BUREAU V. S.

9901 01 NFM

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pay the funeral director, page 3, which will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6701

CERTIFICATE OF DEATH

Reg. Dist. No.

06695

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 113 Brooklyn Ave		d. STREET ADDRESS 113 Brooklyn Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES RUSSELL YOHE		4. DATE OF DEATH Month JUNE Day 15 Year 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1900
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician (Piano-Organ)		10b. KIND OF BUSINESS OR INDUSTRY W.B.O.C. Worked Radio-T.V.	
11. BIRTHPLACE (State or foreign country) Wilmington, Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Yohe		14. MOTHER'S MAIDEN NAME Etha Parsons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Claudia Yohe (Wife)		Address 113 Brooklyn Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) Compensated - Heart		INTERVAL BETWEEN ONSET AND DEATH sudden 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 to June 15, 1956 , that I last saw the deceased alive on June 14, 1956 , and that death occurred at 12 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 334 Camden Ave. (Office) DATE SIGNED June 1956			
ACTUAL SIGNATURE William D. Gray M.D.		PHYSICIAN'S NAME (Type) Dr. William D. Gray M.D. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 18, 1956	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME-SALISBURY, MD.		24a. REC'D BY REGISTRAR DATE 6-19-56	
24b. REGISTRAR'S SIGNATURE Mary W. Hollaway			

...the

From the Center for the Study of the History of the Book and the Written Word, University of Toronto

BUREAU V. S.

9561 61 NOV

RECEIVED